EMERGENCY HEALTH CARE PLAN

Place child's picture here

ALLERGY TO: _____

Student's
Name: _____ D.O.B.:_____ School:_____

Asthmatic Yes ☐ * High risk for severe reaction No ☐

Signs of an allergic reaction include:

Systems:	**Symptoms:**
MOUTH	itching & swelling of the lips, tongue or mouth
THROAT *	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
SKIN	hives, itchy rash and/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting and/or diarrhea
LUNG *	shortness of breath, repetitive coughing and/or wheezing
HEART *	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If ingestion is suspected, give _____
   (medication/dose/route)

   and _____ immediately.

2. CALL RESCUE SQUAD: _____

3. CALL: Mother:_____ Father:_____ or emergency contacts.

4. CALL: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____ _____M.D. _____
Parent Signature Date Doctor's Signature Date

ENERGENCY CONTACTS

1. _____
Relation:_____Phone:_____

2. _____
Relation:_____Phone:_____

3. _____
Relation:_____Phone:_____

TRAINED STAFF MEMBER'S

1. _____ Door_____

2. _____Door_____

3. _____Door_____

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. **Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription**. This form **MUST** be completed for **EACH** individual medication ordered by the prescriber. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? ☐ Yes ☐ No

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration_____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication_____

Plan of Management for Side Effects_____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain_____

Prescriber's Name_____ Phone Number (_____)_____

Prescriber's Address_____ Town_____

Signature_____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program_____ Today's Date ____/____/____

Child's Name_____ Address_____ Town_____

Name of Parent/Guardian Authorizing Administration of Medication_____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain:_____

Address_____ Town_____ Phone Number (____)_____

Signature of Parent/Guardian Authorizing Administration of Medication_____

Name of Childcare Personnel Receiving Written Authorization and Medication_____

Title/Position_____ **Signature (in ink)**_____